		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155218	B. WIN			07/28/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
DECENC		2			REAT LAKES DRIVE	
	CY PLACE OF DYEF				IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	IAG	DLI ICILIACI)	DATE
F0000						
	This visit was for	r the Investigation of	FO	000	The facility requests that this	
	Complaint IN000	_		000	plan of correction be considered	
	Complaint 11400075712.				its credible allegations of	
	Complaint INO00	093712 substantiated,			compliance.	
	1 ^	iciencies related to the			-	
					Submission of this response	and
	"	ted at F 225, F 226, F			Plan of Correction is not a le	gal
	272, and F 323.				admission that a deficiency e	exists
					or that this statement of	
	Unrelated deficiencies cited. Survey dates: July 27 and 28, 2011				deficiency was correctly cite	
					and is also not to be construe	l l
					an admission of interest agai	
					the facility, the Administrato	
	Facility number:		any employee, agents, or other			
	Provider number	: 155218			individuals who draft or may	
	AIM number: 10	00266720			discussed in the response and	
					Plan of Correction. In additi	
	Survey team:				preparation and submission of Plan of Correction does not	or the
	Janelyn Kulik, R	N			constitute an admission or	
					agreement of any kind by the	<u>, </u>
	Census bed type:				facility of the truth of any fac	• • • • • • • • • • • • • • • • • • •
	SNF/NF: 136				alleged or the corrections of	
	Total: 136				conclusion set forth in this	
					allegation by the survey ager	ncy.
	Census payor typ	ne.				·
	Medicare: 28	/ - •			Accordingly, the facility has	
	Medicaid: 83				prepared and submitted this	Plan
	Other: 25				of Correction prior to the	
	Total: 136				resolution of appeal of this n	natter
	101.130				solely because of the	
	Commiss 0				requirements under State and	l
	Sample: 8				Federal law that mandates	
		1 0			submission of the Plan of	
	These deficiencie	es also reflect state			Corrections a condition to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FXWC11

Facility ID:

000123

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155218	A. BUILDING	00	07/28/2011
			B. WINGSTREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			REAT LAKES DRIVE	
	CY PLACE OF DYE			IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	· ·			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) accordance with 410 IAC ompleted 8/1/11	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION DATE d etion in

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155218	B. WING		07/28/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			REAT LAKES DRIVE	
REGENO	CY PLACE OF DYE	₹	l l	IN46311	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=D	have been found of or mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State v concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for a aide or other facility staff to de registry or licensing			
	violations involving abuse, including ir and misappropriat reported immediat the facility and to with State law thro (including to the Sagency).	ensure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are tely to the administrator of other officials in accordance ough established procedures tate survey and certification			
	alleged violations and must prevent the investigation is The results of all in reported to the addrepresentative and accordance with State survey and oworking days of the	nvestigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 e incident, and if the alleged d appropriate corrective			
	facility failed to allegation of abut to the Administra	review and interview the ensure every suspected se was reported promptly ator or the Director of 3 allegations of abuse	F0225	F – 225 It is the practice of this facili ensure the highest quality of is afforded our residents.	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLE	ETED
		155218	B. WIN			07/28/20)11
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	£		2300 GI	REAT LAKES DRIVE		
	CY PLACE OF DYE	R		DYER,	IN46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	•	.1	DATE
	reviewed in a sai	mple of 8. (Resident #B)			Consistent with this practice,	tne	
					following has been done:		
	Findings include				The corrective action taken f	or	
					the residents found to have b	1	
	The record for Resident #B was reviewed				affected by the deficient prac	1	
	on 7/28/11 at 9:2	25 a.m. The resident's			was:		
	diagnoses includ	led, but were not limited			was.		
	to, lymphoma, p	neumonia, anemia, and			Upon receipt of the		
	hypertension.				information, facility		
					administration immediately	v	
	A nursing note dated 6/16/11 at 2:00 p.m., indicated Social Service #1 followed up				began investigation related		
					Res. B's allegation. C.N.A.	#3	
	with the resident	for emotional distress.			is no longer employed at th	is	
	The resident den	ied distress. The resident			facility. C.N.A. #2 has been	ı	
	continued to stat	ed, "The CNA took (sic)			counseled on timely reporti	ng	
		I do not want her in any			of abuse allegations.		
	` ′	lesident) was reassured					
	,	d administration was			The corrective action taken f	or	
	going through th	e proper measures to			those residents having the potential to be affected by the		
		ter. The resident was			same deficient practice is:		
		cus on her health and			same deficient practice is.		
	1	The staff will continue to			Interviewable residents wei	re	
	monitor.				asked if they had any issues		
					related to abuse and custon		
	Δ reportable inci	ident with investigation			service. No other issues we		
	1 ^	the Administrator and			identified through this proc	1	
	1 .	8/11 at 12:00 p.m. The			•		
		sheet was dated 6/16/11.					
					The measures put into place		
		s not dated. The incident			systemic change made to ens		
		nt #B told a therapist that			the deficient practice does no	ot	
		d a staff member was			recur is:		
		he identified the staff					
	member as CNA				Facility staff has been		
	"After investigat	ion, it was found the			re-educated by the ED and		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 07/28/20	ETED
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	help her with (Reneeds at the time waited longer that she needed. (Resconfirmed that she CNA when she countries but stated that the attitude regarding Although facility that abuse did no was written up for related issues due #3's name) was a warning unrelated write up resulted the facility. An Alleged Abuse Exploitation Inverprovided in the in "Res (resident) stock CNA answered. CNA she need (stearful (sic) r/t (resident) from the call (sic) light barreturned. Res (resident) forget it I with the countries forget it I with the countries of the	estigation worksheet envestigation, indicated tates her call light was on Res (resident) informed ic) to be changed. CNA elated to) res (resident) cheotomy). States she d (sic) CNA who is . 10 min (minutes) later			Nursing Administration reto timely response to and method of reporting abuse allegations. Department managers are conducting of interviews with residents to ensure resident needs are limet. Any issues are immediately addressed. To ensure the deficient pract does not recur, the monitoring system established is: A Performance Improvem tool has been developed the evaluates timely reporting allegations of abuse. Department Mangers to complete tool twice weekly interviewable residents and present results at daily climmeeting to ensure timely resolution when necessary. These results will be review at the monthly PI meeting ongoing per facility protocome.	laily o peing ice ng ent at for d nical	

000123

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155218	A. BUI		00	07/28/2	
		100210	B. WIN		DDDEGG CITY GTATE ZID CODE	0172072	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE		
REGENO	CY PLACE OF DYE	२			IN46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		orry and explained she					
		would hurt her d/t (due to)					
	,	otomy). Res (resident)					
		pology and fell (sic) the					
		n their fault (sic). It was					
	a simple misunde	_					
		x place in the resident's					
		m was Resident #B. The					
	perpetrator was (JNA #3.					
	A memo to the A	dministrator dated					
		d "Pt. (patient) stated she					
	· ·	other anyone because one					
		call light twice and that					
		ame in and yelled at her,					
	pt (patient) stated	d she/pt (patient)got very					
	upset and wanted	l to report the CNA, pt					
	(patient) stated th	ne CNA #2 came into her					
	room to clam her	down and "begged" pt					
	(patient) not to re	eport the CNA. This					
		with case manager." The					
		d this happened this last					
	Thursday or Frid	ay.					
	A written statem	ent from CNA #3,					
		ident's light was on and					
		eated she needed to be					
		3 told the resident she					
	ı ~	JA #2. The resident put					
	_	ent back in the room and					
		l again - I need to be					
		her I needed to get CNA					
	_	n't know how to take care					
		t stated, I need to be					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155218	B. WING	1.10		07/28/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		- 1		REAT LAKES DRIVE		
	Y PLACE OF DYE	२		DYER, I			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC1)		DATE
	_	CNA left the room got					
	CNA #2 and they	took care of her needs.					
	A written statement from CNA #2,						
	indicated he did	not report what had					
	happened because	se he thought everything					
	was fine between	n CNA #3 and Resident					
	#B.						
	Interview with the Administrator on						
	7/28/11 at 12:30 p.m., indicated CNA #2						
	knew of the incid	dent between CNA #3 and					
	Resident #B and	l did not report the					
		been educated to report					
	all incidents.	occir cadeated to report					
	an incidents.						
	This Faderal tag	relates to complaint					
	IN00093712.	relates to complaint					
	INUUU93/12.						
	2.1.20(-)						
	3.1-28(c)						
F0226	•	evelop and implement					
SS=D		d procedures that prohibit lect, and abuse of residents					
	_	ion of resident property.					
		review and interview the	F022	₂₆	F – 226		08/19/2011
		ensure the facility					
	_	se policy regarding			It is the practice of this facilit	-	
	reporting all alle				ensure the highest quality of	care	
		_			is afforded our residents.		
	· ·	he Administrator or the			Consistent with this practice,	the	
	Director of Nurs	ing for 1 of 3 allegations			following has been done:		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155218	B. WIN	G		07/28/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
		_		1	REAT LAKES DRIVE	
REGENC	CY PLACE OF DYEF	₹		DYER,	IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
		d in a sample of 8.			The corrective action taken f	
	(Resident #B)				the residents found to have b	
	Findings include:				affected by the deficient prac	
					was:	, tice
					Upon receipt of the	
		esident #B was reviewed			information, facility	
		5 a.m. The resident's			administration immediately	y
	_	ed, but were not limited			began investigation related	
		neumonia, anemia, and			Res. B's allegation. C.N.A.	#3
hypertension.				is no longer employed at th	is	
					facility. C.N.A. #2 has been	
	A nursing note da	ated 6/16/11 at 2:00 p.m.,			counseled on timely reporti	ng
	indicated Social	Service #1 followed up			of abuse allegations	
	with the resident	for emotional distress.				.
	The resident deni	ed distress. The resident			The corrective action taken f	or
	continued to state	ed, "The CNA took (sic)			those residents having the	_
	care of me.(sic)	I do not want her in any			potential to be affected by the same deficient practice is:	
	trouble." Res (R	esident) was reassured			Interviewable residents wei	·e
	staff member an	d administration was			asked if they had any issues	
	going through the	e proper measures to			related to abuse and custon	
	address this matt	er. The resident was			service. No other issues we	re
	encouraged to fo	cus on her health and			identified through this proc	ess.
	getting better. The	ne staff will continue to				
	monitor.				The measures put into place	
					systemic change made to ens	l l
	A reportable inci-	dent with investigation			the deficient practice does no	ot
	was provided by	the Administrator and			recur is:	
		/11 at 12:00 p.m. The			Facility staff has been	
	initial fax cover s	sheet was dated 6/16/11.			re-educated by the ED and Nursing Administration rel	atad
	The incident was	not dated. The incident			to timely response to and	aicu
	indicated Resider	nt #B told a therapist that			method of reporting abuse	
		l a staff member was			allegations. Department	
		ne identified the staff			managers are conducting d	aily
	member as CNA				interviews with residents to	· .
					ļ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/28/2011	
	PROVIDER OR SUPPLIER		P. WIII	STREET A	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE N46311	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	above CNA was help her with (Re	tion, it was found the trying to find someone to esident #B's name) care			ensure resident needs are b met. Any issues are immediately addressed.	eing
	needs at the time waited longer that she needed. (Resconfirmed that she confirmed that she confirmed that she call (sic) light bar returned. Res (resident).	in usual to get the care sident #B's name) in usual to get the care sident #B's name) in usual to get the care sident #B's name) in was frustrated with the ame back into the room, in a condition of the care for her. It was able to conclude it occur, (CNA #3's name) or customer service in the concern. (CNA in the concern. (To ensure the deficient pract does not recur, the monitorin system established is: A Performance Improvement tool has been developed that evaluates timely reporting allegations of abuse. Department Mangers to complete tool twice weekly interviewable residents and present results at daily clin meeting to ensure timely resolution when necessary. These results will be review at the monthly PI meeting ongoing per facility protocome.	ent at for on l ical
	just forget it I wi	ll do it myself. Res l CNA (sic) to touch her.				

		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155218	B. WIN			07/28/20	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	REAT LAKES DRIVE		
REGENO	CY PLACE OF DYE	₹		DYER,	IN46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		the room shortly and					
		orry and explained she					
		would hurt her d/t (due to)					
	,	otomy). Res (resident)					
		pology and fell (sic) the					
		h their fault (sic). It was					
	a simple misunde	· ·					
		k place in the resident's					
		m was Resident #B. The					
	perpetrator was (CNA #3.					
	A mamo to the A	dministrator dated					
		d "Pt. (patient) stated she					
		other anyone because one					
		call light twice and that					
		ame in and yelled at her,					
	' '	d she/pt (patient)got very					
	1 4 4	t sne/pt (patient)got very					
	1 ^	ne CNA #2 came into her					
		down and "begged" pt					
		eport the CNA. This					
	, ,	*					
	_ ^ ^	with case manager." The d this happened this last					
		• •					
	Thursday or Frid	ay.					
	A written stateme	ent from CNA #3,					
		ident's light was on and					
		cated she needed to be					
		\$\frac{1}{3}\$ told the resident she					
	_	JA #2. The resident put					
	_	ent back in the room and					
	_	l again - I need to be					
		her I needed to get CNA					
	_	n't know how to take care					

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155218	A. BUI		00	07/28/2	
		100210	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0172072	
NAME OF F	PROVIDER OR SUPPLIER			1	REAT LAKES DRIVE		
REGENO	CY PLACE OF DYER			1	IN46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		,	+	ING			DATE
	of her. "Resident stated, I need to be changed now." CNA left the room got						
	CNA #2 and they took care of her needs.						
	CNA #2 and they took care of her needs.						
	A written stateme	ent from CNA #2,					
		not report what had					
		e he thought everything					
		CNA #3 and Resident					
	#B.						
	The Abuse Policy was provided by the						
	Administrator on	7/27/11 at 9:30 a.m.					
		sexual, physical, and					
		poral punishment,					
	I -	ision, and neglect of the					
		as mistreatment, neglect,					
		ation of resident property					
	are strictly prohil						
		e and Investigating an					
		n procedure included, but					
		o, "Contact the Executive					
	Director and Dire	ector of Nursing					
	immediately.						
	Intervious:41- 41-	ne Administrator on					
		p.m., indicated CNA #2					
 		lent between CNA #3 and					
		did not report the					
		been educated to report					
	all incidents.	occir caucated to report					
	an incidents.						
	This Federal tag	relates to complaint					
	IN00093712.	r					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155218	B. WING		07/28/2011
	ROVIDER OR SUPPLIER		2300 G	ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE IN46311	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	T	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0272 SS=D	The facility must of periodically a comstandardized represent resident's further assessment of a recomplete ach resident's further assessment of a recomplete ach resident's further assessment of a recomplete after a review for falls it.	conduct initially and prehensive, accurate, oducible assessment of nctional capacity. The accomprehensive esident's needs, using the ne State. The assessment ast the following: demographic information; as; and health conditions; and health conditions; and status;	F0272	F – 272 It is the practice of this facili ensure the highest quality of is afforded our residents. Consistent with this practice.	08/19/2011 ty to care
			1	1	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	A. BUILDIN		STRUCTION 00	(X3) DATE SURVEY COMPLETED 07/28/2011
	PROVIDER OR SUPPLIER		B. WING O772572011 STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	broken leg and the (Resident #H)	ne resident being moved.			following has been done:	
	Findings include	:			The corrective action taken for the residents found to have be affected by the deficient prace	een
	on 7/27/11 at 11: diagnoses include to, dementia, urin hip fracture, dehy	esident #H was reviewed 30 a.m. The resident's ed, but was not limited hary tract infection, right ydration, glaucoma,			was: Res. H returned to the facility. 7/15/11. Nurse #1 is no long employed by the facility. The corrective action taken for	ger
	(weak bones).	pression, and osteopenia			those residents having the potential to be affected by the same deficient practice is:	
	a.m., indicated the resident's room be was observed lying the bathroom does she was going to	the de nurse was called to the yethe CNA. The resident on the floor next to or. The resident indicated the bathroom. The resed while on the floor.			Facility conducted an audit the past 30 days of falls to ensure proper assessment a follow through was complet per facility standards. No issues with assessment were identified.	nd ted
	femur (upper leg	ed. The resident ight pain to the right). On a scale of 1 to 10			The measures put into place a systemic change made to ens the deficient practice does no recur is:	ure
	to the wheelchain she was further a had no leg deform and was able to be resident complain on a scale of 1-10	The resident was assisted and then to bed where assessed. The resident mities or discoloration pear slight weight. The ned of pain at a level of 6 D. An order was received			Licensed staff have been re-educated on process to follow post resident fall. Education to include physic assessment, family and MD notification and immediate intervention implement	
	fracture and the r	e right leg to rule out a resident was to be on bed y results were obtained.			towards prevention of futur occurrence. A "Quick Guic Falls" has been posted at ea	le to

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155218	B. WIN			07/28/201	1
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	I KO VIDEK OK SUFFLIEF	· ·		1	REAT LAKES DRIVE		
	CY PLACE OF DYE			<u> </u>	IN46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re (COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	The resident will				nurse's station as a visual		
	monitored for pa	in. Pain medication was			reminder of this education.		
	given.				T		
					To ensure the deficient practi		
	A nursing note d	ated 7/11/11 at 6:30 a.m.,			does not recur, the monitorin	g	
	indicated the res	ident was reassessed and			system established is:		
	noted to have a r	otated right hip. The			A Doufoumor I		
		vas 7 on a scale of 1-10.			A Performance Improveme tool has been developed tha		
	_	tioner was called and			will monitor that proper po	I .	
	1 *	he right leg being			fall assessments have been	si	
		d out and the right leg			conducted properly in		
	1	in the other leg. An order			accordance with facility pol	licy	
		the resident to be sent to			The DNS or Designee will	iley.	
					complete PI tools weekly fo	r	
	the nospital for e	evaluation and treatment.			four weeks, monthly for a	•	
					quarter and quarterly		
	_	ated 7/11/11 at 3:35 p.m.,			thereafter with results being	g	
		try for 7/11/11 at 6:30			forwarded to the PI commi	-	
		arrived and received			for further review until 100		
	report from the r	night nurse that the			compliance is achieved.		
	resident fell duri	ng the night and had					
	slight pain and re	eceived Tylenol (pain					
	medication); Th	e nurse did rounds and					
	noticed resident	in pain and right leg					
		and painful to touch or					
	bend. The nurse	•					
		explained what the nurse					
	1 ^	n order was received to					
		t to the emergency room					
	for evaluation ar						
	Tor evaluation at	ia a camioni.					
	A hospital Histor	ry and Physical dated					
	_	ed the resident was					
	· ·	/11. The History of					
		-					
	Present Iliness:	The patient "was				1	

STATEMENT OF DEF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/28/2	LETED
NAME OF PROVIDER			p. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311		
`	CH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
admitt Emerg on the went t lost he fell an comm the rig A post the fal compl unwitt at the ordere reside was ne order the ho The in by the review dated events indica includ 12:20- room discov with h door. (Nurse	ed to the hogency Room evening of o turn arouser balance. It dat this time inuted interest the hip (right fall evaluated by Numbersed. The time of the ed to rule out was received spital. Administrated at 3:00 7/13/11 with fall ed (Resided 12:30 a.m., was closed for the regret back against a called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to eat 1's name of the regret at 1 called to 1 called	ospital through the after undergoing a fall admission while she and and had subsequently. The patient subsequently are did develop a attrochanteric fracture of at hip fracture). Attion indicated the date of all at 12:30 a.m. and are #1. The fall was bere was no injury noted fall. An x-ray was at a fracture. The becked and discoloration are ident's right hip. An ed to send the resident to a of the fall was provided after on 7/27/11 and p.m. A typed interview of the CNA #1 regarding the and fall of Resident #H, the assignment that at #H's name). At about a finite the door to here. When I tried to enter, I sident sitting on the floor ainst the closed bathroom the nurse to help. When by came into the room, he sident to stand up and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SI COMPLE 07/28/20	ETED
	PROVIDER OR SUPPLIER		2300 G	NDDRESS, CITY, STATE, ZIP CO REAT LAKES DRIVE IN46311	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	stand, my leg is ther and said that we both got her in then got her to be the w/c (wheelch her on her (unaff that she was just assist on South u and walk and wa with it, so I knew wasn't crying, bubad. I think (Nu some medication on her at (sic) at and changed her hurt her, so I did was able to get it remember seeing back into the room. A performance In 7/11/11 for Nursfor the counseling the neglect to make significant injury. Tylenol shortly a documentation we check relative to documentation we pain and non sequevident.	but she said, "no, "I can't broken." He argued with it wasn't broken. Then nto the wheelchair. I sed by standing her from sair) and quickly pivoting sected) leg. I remember a one-person, minimal nit-she was able to stand as almost independent where she had changed. She at said that it hurt really rese #1's name) gave her are I went back in to check between 2:30 and 3:00, brief. She said it still in't turn her very far, but a changed. I don't are (Nurse #1's name) go are during my shift." I mprovement Form dated the reason governective action was sonitor resident with a from fall despite giving after the fall. The was inconsistent on Neuro injury sustained. The was incomplete related to usential negligence is				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	onstruction 00	(X3) DATE SURVEY COMPLETED			
		155218	A. BUILDING B. WING		07/28/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311					
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR 7/28/11 at 12:30 not know if the a Resident #H fell. to the interview was concern the residuassessed prior to further indicated management the Nurse #1 he legal resident being madue to the discrept documentation it not been assessed resident's fall. To for this and other	being moved. She CNA #2 had told resident had informed was broken prior to the oved. She also indicated pancy in the nurse's was felt the resident had d properly after the he nurse was terminated	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE			
F0281 SS=D	facility must meet quality.	ded or arranged by the professional standards of review and interview the	F0281	F – 281	08/19/2011			
		ensure professional	10201		0,7,7,200			
	Licensed Practica	lity were met related to a al Nurse (LPN) not		It is the practice of this facili ensure the highest quality of is afforded our residents.	-			
	assessing a reside	ent for 1 or 3 residents		Consistent with this practice,	the			

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155218	B. WIN			07/28/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DECENC		2		1	REAT LAKES DRIVE	
	CY PLACE OF DYEF	Κ			IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAU				IAG	following has been done:	DATE
		s in a sample of 8 related			following has been done.	
		ng and complaining of a			The corrective action taken f	or
		ne resident being moved.			the residents found to have b	
	(Resident #H)				affected by the deficient prac	
	F: 1: : 1 1				was:	
	Findings include	•				
		.1 . //***			Res. H returned to the facil	ity
		esident #H was reviewed			7/15/11. Nurse #1 is no long	ger
		30 a.m. The resident's			employed by the facility.	
	-	ed, but was not limited				
	l ' '	nary tract infection, right			The corrective action taken f	or
		ydration, glaucoma,			those residents having the	
	hypertension, dep	pression, and osteopenia			potential to be affected by th	e
	(weak bones).				same deficient practice is:	
					Facility conducted an audit	of
		ated 7/11/11 at 12:28			the past 30 days of resident	l l
		e nurse was called to the			falls to ensure proper	
		y the CNA. The resident			assessment and follow thro	ugh
	I	ng on the floor next to			was completed per facility	
	the bathroom doo	or. The resident indicated			standards. No issues with	
		the bathroom. The			assessment were identified	
		essed while on the floor.				
	There were no de				The measures put into place	l l
	discoloration not	ed. The resident			systemic change made to ens	
	complained of sli	ight pain to the right			the deficient practice does no	ot
	femur (upper leg)). On a scale of 1 to 10			recur is:	
	her pain was 4.	The resident was assisted			Licensed staff have been	
	to the wheelchair	and then to bed where			re-educated on process to follow post resident fall.	
	she was further a	ssessed. The resident			Education to include physic	.al
	had no leg deform	nities or discoloration			assessment, family and MD	l l
	and was able to b	ear slight weight. The			notification and immediate	
		ned of pain at a level of 6			intervention implement	
	_	O. An order was received			towards prevention of futur	re
	for an x-ray of th	e right leg to rule out a			occurrence. A "Quick Guic	l l

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 07/28/2	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	rest until the x-ra The resident will monitored for paragiven. A nursing note dindicated the resent to have a resident's pain where the summade aware of the externally rotated being shorter that was received for the hospital for externally rotated being shorter that was received for the hospital for externally rotated being shorter that was received for the hospital for externally rotated late enamedicated late enamedicated late enamedicated late enamedication); The noticed resident rotated outwards bend. The nurse practitioner and had assessed. A send the resident for evaluation and resident for evaluation an	resident was to be on bed by results were obtained. I continue to be an explained and resident was reassessed and cotated right hip. The as 7 on a scale of 1-10. It ioner was called and the right leg being dout and the right leg and the other leg. An order the resident to be sent to evaluation and treatment. The stated 7/11/11 at 3:35 p.m., try for 7/11/11 at 6:30 arrived and received hight nurse that the leg the night and had beceived Tylenol (pain the nurse did rounds and in pain and right leg and painful to touch or called the nurse explained what the nurse in order was received to to the emergency room.			Falls" has been posted at enurse's station as a visual reminder of this education. To ensure the deficient pract does not recur, the monitoring system established is: A Performance Improvement tool has been developed that will monitor that proper postall assessments have been conducted properly in accordance with facility poor The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being for further review until 100 compliance is achieved.	ach ice ag ent at est	
	7/14/11, indicate	ed the resident was					

000123

STATEMENT OF DEFIC AND PLAN OF CORREC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		LDING	NSTRUCTION 00	1 '	E SURVEY PLETED 12011
NAME OF PROVIDER OF			p. wiiv	STREET A	NDDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	I	
PREFIX (EAC	H DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
Present admitte Emerge on the eath went to lost her fell and commit the right. A post the fall comple unwitner at the time ordered resident was not order with the host. Review Nursing Code at retrieve PLA.IN practical which in "Know plannin health sindivide	Illness: d to the heavy Roor evening of turn arous balance. at this timuted intent hip (right was 7/11) ted by Nuessed. The me of the to rule of the to rule of the to the ras received pital. Tof the Ing: A compand Indianal and on 7/30 Ill. Gov, indianal nurse should be and utilizing, implemental patients and patients.	711. The History of The patient "was ospital through the in after undergoing a fall of admission while she and and had subsequently The patient subsequently ine did develop a rtrochanteric fracture of int hip fracture). Attion indicated the date of of the fall was ere was no injury noted of fall. An x-ray was out a fracture. The elecked and discoloration resident's right hip. An old to send the resident to diana State Board of pilation of the Indiana of Administrative Code of the following out was not limited to, we the nursing process in menting, and evaluating ond nursing care to the of to client." "Assess the of patient/client, in					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155218	B. WIN			07/28/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DECENC		7			REAT LAKES DRIVE		
	CY PLACE OF DYER			DYEK,	IN46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU			-	IAG	DEI TOLERO I I		DATE
	l "	other members of the					
	health care team,	•					
		health goals." "Evaluate					
	_	client the status of goal					
		basis for reassessment,					
		orities, and new goals					
	setting for contri						
	modification of t	he plan of care."					
	_	n of the fall was provided					
	*	ator on 7/27/11 and					
		p.m. A typed interview					
		th CNA #1 regarding the					
	events of 7/11/11	and fall of Resident #H,					
	indicated, "I had	the assignment that					
	included (Reside	nt #H's name). At about					
	12:20-12:30 a.m.	, I noticed the door to her					
	room was closed	. When I tried to enter, I					
	discovered the re	sident sitting on the floor					
	with her back aga	ainst the closed bathroom					
	door. I called to	the nurse to help. When					
	(Nurse #1's name	e) came into the room, he					
	tried to get the re	sident to stand up and					
	walk to her bed,	but she said, "no, "I can't					
	stand, my leg is b	oroken." He argued with					
	her and said that	it wasn't broken. Then					
	we both got her i	nto the wheelchair. I					
	T	ed by standing her from					
	_	air) and quickly pivoting					
	· ·	ected) leg. I remember					
	,	a one-person, minimal					
		nit-she was able to stand					
		s almost independent					
		she had changed. She					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND FLAN	OF CORRECTION	155218	A. BUI		00	07/28/2	
		100210	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0172072	
NAME OF	PROVIDER OR SUPPLIEF	₹			REAT LAKES DRIVE		
REGEN	CY PLACE OF DYE	R		1	IN46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	it said that it hurt really					
	`	rse #1's name) gave her					
	1	n. I went back in to check					
	` ′	between 2:30 and 3:00,					
	1	brief. She said it still					
	•	n't turn her very far, but					
		t changed. I don't					
	remember seeing	g (Nurse #1's name) go					
	back into the roc	om during my shift."					
	A performance I	mprovement Form dated					
	7/11/11 for Nurs	e #1 indicated the reason					
	for the counselin	g/corrective action was					
	the neglect to mo	onitor resident with					
	significant injury	from fall despite giving					
	Tylenol shortly a	after the fall. The					
	documentation v	vas inconsistent on Neuro					
	check relative to	injury sustained. The					
	documentation v	vas incomplete related to					
	pain and non sec	quential negligence is					
	evident.						
	Interview with the	ne Administrator on					
	7/28/11 at 12:30	p.m., indicated she did					
	not know if the a	nlarm was on when the					
	Resident #H fell	. She also indicated due					
	to the interview	with CNA #1 there was					
	concern the resid	lent had not been					
	assessed prior to	being moved. She					
	_	CNA #2 had told					
	1	resident had informed					
	1	was broken prior to the					
	1	oved. She also indicated					
	1	pancy in the nurse's					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155218	A. BUILD B. WING	ING		07/28/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR documentation it not been assessed resident's fall. T for this and other	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) was felt the resident had d properly after the he nurse was terminated rissues. relates to complaint		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLET DATE	
F0323 SS=G	environment remain hazards as is possible receives adequated devices to prevent Based on record facility failed to were in place, as after a fall for 2 falls in a sample not being in place assessed after a resident going to fractured right his resident being training to service of the sample factors.	review and interview the ensure fall interventions sessments completed of 3 residents review for of 8 related to an alarm e and the resident not fall, resulting in the the hospital with a p (Resident #H) and a unsferred by one staff e hoyer (mechanical) lift.	F032	23	F – 323 It is the practice of this facility ensure the highest quality of is afforded our residents. Consistent with this practice, following has been done: The corrective action taken for the residents found to have be affected by the deficient practives: Res. H returned to the facility 7/15/11. Res. E returned to facility on 7/11/11.	the or een tice	2011
	reviewed on 7/27	r Resident #H was 7/11 at 11:30 a.m. The ses included, but was not			The corrective action taken for those residents having the	DT .	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FXWC11 Facility ID: 000123

If continuation sheet Page 23 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155218 07/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DRIVE REGENCY PLACE OF DYER DYER. IN46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE potential to be affected by the limited to, dementia, urinary tract same deficient practice is: infection, right hip fracture, dehydration, glaucoma, hypertension, depression, and Full facility audit was done to osteopenia (weak bones). ensure that preventative measures put in place for the A nursing note dated 7/11/11 at 12:28 prevention of falls were in a.m., indicated the nurse was called to the place as indicated. Issues were resident's room by the CNA. The resident immediately addressed and was observed lying on the floor next to additional assessment the bathroom door. The resident indicated completed as necessary. A full she was going to the bathroom. The facility audit was also resident was assessed while on the floor. completed to ensure the proper There were no deformities or mode of transfer for each resident is reflected on the discoloration noted. The resident current C.N.A. assignment complained of slight pain to the right sheet. femur (upper leg). On a scale of 1 to 10 Facility conducted an audit of her pain was 4. The resident was assisted the past 30 days of falls to to the wheelchair and then to bed where ensure proper assessment and she was further assessed. The resident follow through was completed had no leg deformities or discoloration per facility standards. No and was able to bear slight weight. The issues with assessment were resident complained of pain at a level of 6 identified. on a scale of 1-10. An order was received The measures put into place and for an x-ray of the right leg to rule out a systemic change made to ensure fracture and the resident was to be on bed the deficient practice does not rest until the x-ray results were obtained. recur is: The resident will continue to be monitored for pain. Pain medication was **Mandatory competency testing** given. on proper lift procedures with return demonstration A nursing note dated 7/11/11 at 6:30 a.m., completed for all care staff. indicated the resident was reassessed and Care staff has been re-educated noted to have a rotated right hip. The on following C.N.A. care sheets and in the event a change was resident's pain was 7 on a scale of 1-10. Facility ID:

NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 (X5) PREFIX (ACH DEFICIENCY DYER) PREFIX (ACH DEFICIENCY DYER) PREFIX (ACH DEFICIENCY) PREFIX (A	STATEMENT OF DEFICIENCE	i '	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m.,	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
REGENCY PLACE OF DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., 2300 GREAT LAKES DRIVE DYER, IN46311 (X5) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF		155216	B. WIN			0772072011
DYER, IN46311	NAME OF PROVIDER OR SUP	PLIER				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., ID PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE COMPLETION DATE **COMPLETION DATE *	DECENCY DI ACE OF	IVED				
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., PREFIX TAG PREF					1140311	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., TAG CROSS-REFERENCED TO THE APPROPRIATE DATE necessary, reporting the need for a change to the nurse. Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement					PROVIDER'S PLAN OF CORRECTION	
The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., The nurse practitioner was called and necessary, reporting the need for a change to the nurse. Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement	(CROSS-REFERENCED TO THE APPROPRIA	TE
made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., for a change to the nurse. Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement		, , , , , , , , , , , , , , , , , , ,		1710	necessary reporting the ne	
externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement	1					
being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., The state of the resident of the resident to be sent to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement						
was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., The follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement						
the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., Education to include physical assessment, family and MD notification and immediate intervention implement	I -	_			-	
A nursing note dated 7/11/11 at 3:35 p.m., intervention implement					Education to include physic	cal
A nursing note dated 7/11/11 at 3:35 p.m., intervention implement	ule nospitai	or evaluation and treatment.		I)
intervention implement	A	4- 4-4-4 7/11/11 -4 2-25				
indicated late entry for //11/11 at 6:30 towards prevention of future	I	_			_	
		-			<u> </u>	
a.m The nurse arrived and received occurrence. A "Quick Guide to						I
report from the night nurse that the Falls" has been posted at each		_			<u> </u>	ach
resident fell during the night and had slight pain and received Tylenol (pain reminder of this education.						
onghi pam ana rootivoa Tytenor (pam	• •				reminder of this education.	
medication); The nurse did rounds and noticed resident in pain and right log To ensure the deficient practice	· ·				To ensure the deficient pract	ice
does not require the monitoring					*	
rotated outwards and paintin to touch of		-				.5
bend. The nurse called the nurse A Performance Improvement					_	ent
practitioner and explained what the nurse tool has been developed that	1 -	_			_	I
had assessed. An order was received to will monitor that proper post					will monitor that proper po	ost
send the resident to the emergency room fall assessments have been					fall assessments have been	
for evaluation and treatment. conducted properly in	for evaluation	n and treatment.				
accordance with facility policy.						licy.
A hospital History and Physical dated The DNS or Designee will	1 ^	-			_	
7/14/11, indicated the resident was complete PI tools weekly for	·					or
admitted on 7/11/11. The History of four weeks, monthly for a					_	
Present Illness: The patient "was quarter and quarterly thereafter with results being		-				g .
admitted to the nospital through the forwarded to the PI committee		-				_
Emergency Room after undergoing a fall for further review until 100%	I					
on the evening of admission while she compliance is achieved.	on the eveni	g of admission while she				
went to turn around and had subsequently A Performance Improvement						ent
lost her balance. The patient subsequently tool has been developed that	lost her bala	ice. The patient subsequently			_	I
fell and at this time did develop a will monitor C.N.A.'s use of	fell and at the	s time did develop a			-	
comminuted intertrochanteric fracture of Mechanical Lifts. The DNS or	comminuted	intertrochanteric fracture of			Mechanical Lifts. The DNS	or
the right hip (right hip fracture). Designee will complete PI tools	the right hip	(right hip fracture).			Designee will complete PI t	ools

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		INSTRUCTION 00	(X3) DATE S COMPL		
		155218	A. BUI B. WIN	LDING IG		07/28/20	011
	PROVIDER OR SUPPLIER OF DYER			STREET A	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	ı	
					114-05 11		(115)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
TAG	A physician orde the resident was a wheelchair alarm. A care plan initial problem of risk for requiring assistant approaches incluted, a personal alarwheelchair. A fall assessment 6/9/11 with a scoothe resident was assessment composcore of 15 which was at high risk for the fall was 7/11/1/11/11/11/11/11/11/11/11/11/11/11/	r dated 6/10/11, indicated to have a bed and a		TAG	weekly for four weeks, mor for a quarter and quarterly thereafter with results bein forwarded to the PI commi for further review until 100 compliance is achieved.	athly g ttee	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155218	B. WING		07/28/2011
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DECEN		D.		BREAT LAKES DRIVE	
	CY PLACE OF DYE	K		IN46311	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAU	box for shoes.	LSC IDENTIFTING INFORMATION)	IAU		DATE
		cation of Resident Prior to			
		ek was in the box for			
	wheelchair.	ck was in the box for			
		nterventions were to			
		t every two hours.			
		•			
	1	f Interdisciplinary Team: n when back from			
		n when back from			
	hospital."				
	The investigation	n of the fall was provided			
		rator on 7/27/11 and			
	1 *	p.m. A typed interview			
		th CNA #1 regarding the			
		and fall of Resident #H,			
		the assignment that			
	`	ent #H's name). At about			
		., I noticed the door to her			
		When I tried to enter, I			
		esident sitting on the floor			
	_	ainst the closed bathroom			
		the nurse to help. When e) came into the room, he			
	`				
	1	esident to stand up and			
	•	but she said, "no, "I can't broken." He argued with			
		it wasn't broken. Then			
		into the wheelchair. I			
	1				
	1	ed by standing her from			
	· ·	nair) and quickly pivoting			
		Fected) leg. I remember			
	1	a one-person, minimal init-she was able to stand			
	and walk and wa	s almost independent			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155218		A. BUI	LDING	onstruction 00	(X3) DATE S COMPL 07/28/2	ETED	
		155216	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0112012	011
NAME OF	PROVIDER OR SUPPLIEF	₹		1	REAT LAKES DRIVE		
	CY PLACE OF DYE			1	IN46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG	+	v she had changed. She	+	IAG	,		DAIL
	· ·	it said that it hurt really					
	1 2	rse #1's name) gave her					
	`	1. I went back in to check					
		between 2:30 and 3:00,					
	` ′	brief. She said it still					
		n't turn her very far, but					
		t changed. I don't					
	_	g (Nurse #1's name) go					
	1	om during my shift."					
	A performance I	mprovement Form dated					
	7/11/11 for Nurs	e #1 indicated the reason					
	for the counseling	ng/corrective action was					
	the neglect to mo	onitor resident with					
	significant injury	y from fall despite giving					
	Tylenol shortly a	after the fall. The					
	documentation v	vas inconsistent on Neuro					
	check relative to	injury sustained. The					
	documentation v	vas incomplete related to					
	pain and non sec	quential negligence is					
	evident.						
		tal Factors form dated					
		ed by Nurse #1, indicated					
		ounding, the resident's					
		and both of the yes and no					
	boxes were mark	ked for alarm					
	intact/battery.						
	Interview with the	ne Administrator on					
		p.m., indicated she did					
		alarm was on when the					
		. She also indicated due					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	or connection	155218	A. BUI		00	07/28/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				REAT LAKES DRIVE		
	CY PLACE OF DYE			1	IN46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		with CNA #1 there was		IAU			DATE
	concern the resid						
		being moved. She					
	1 ^	CNA #2 had told					
		resident had informed					
	ı ~	was broken prior to the					
	·	oved. She also indicated					
	1	cancy in the nurse's					
	·	was felt the resident had					
	not been assessed	d properly after the					
		he nurse was terminated					
	for this and other	issues.					
	2. The record of	Resident #E was					
	reviewed on 7/27	7/11 at 2:20 p.m. The					
	resident's diagno	ses included, but was not					
	limited to, periph	eral vascular disease,					
	diabetes mellitus	, hypertension,					
	depression disord	ler, cerebrovascular					
	accident (stroke)	, and left below the knee					
	amputation.						
		ated 7/5/11 at 6:45 a.m.,					
		A notified the nurse the					
		ing pain in her right leg					
		to dress her. When the					
		essed the resident's thigh					
		internally rotated. At					
		er was received to the					
	•	ip x-rayed. At 8:00 a.m.					
		further evaluated and					
	_	al for evaluation and					
	treatment.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155218	A. BUILDING	00	COMPLETED 07/28/2011
		100210	B. WING		07/26/2011
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
REGENO	Y PLACE OF DYE	2		REAT LAKES DRIVE IN46311	
				1	(45)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	A nursing note da	ated 7/5/11 at 3:45 p.m.,			
	_	illed the hospital to check			
		nd was informed the			
	resident was adm	nitted with a hip fracture.			
	A nursing note da	ated 7/5/11 at 6:00 p.m.,			
	indicated late ent	try for 7/5/11 at 8:30 a.m.			
	The nurse was ca	alled to the resident's			
	room to assess th	e resident. The resident			
		distress. Her right leg			
	was swollen to th	• •			
	-	l with some distortion in			
		en her leg was moved the			
	-	ned of severe pain. The			
		ble to move her leg			
		ould not bend her knee.			
	•	d, the resident denied any			
		uries. The resident			
	_	g unusual had happened			
		ave pain in her leg. The			
	resident's speech				
		was alert and oriented			
		nurse explained to the ys needed to be done			
		d to be transferred to the			
	_	. The resident verbalized			
	understanding an				
	anderstanding an	in upivou.			
	A nursing noted a	dated 7/5/11 late entry,			
	_	oximately 8:00 a.m. the			
		the resident regarding			
	_	resident was asked if she			
		she had been transferred			
		of the hoyer lift. The			
		-	•		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	MULTIPLE CO	NSTRUCTION		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00		COMPL	
		155218	B. WI	NG			07/28/2	U11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STA			
				1	REAT LAKES DI	RIVE		
REGENC	CY PLACE OF DYER			DYER,	IN46311			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEF	ICIENCI)		DATE
	resident state, "no							
		d no pain when she was						
		he night but had pain this						
	morning. When							
	questions about v							
	* *	se this pain the resident						
	•	now, I'm so clumsy, I						
		this to myself." The						
		ssured she could talk to						
		any abnormal occurrences						
		thout fear of retaliation						
	and she again sta	· ·						
	abnormal happen	ned that she could recall.						
	A quarterly Minim							
		d 4/7/11, indicated the						
		erstood and understands.						
		n the Brief Interview for						
	Mental Status wh	hich indicated the						
	resident was mod	derately impaired						
	cognitively.							
	A hospital Histor	ry and Physical, indicated						
	the resident was a	admitted on 7/5/11. The						
	Chief Complaint:	: "Status post fall with						
	right hip pain."							
	History of Presen	nt Illness: She fell and						
	was "brought to t	the hospital, was found to						
	have a right hip f	fracture, which is hurting						
	when she moves.	."						
	A care plan initia	ated on 3/1/11, indicated a						
	-	ent being at risk for fall.						
	-	included, but were not						
FORM CMS-2	567(02-99) Previous Version		FXWC1	1 Facility	ID: 000123	If continuation sh	neet Pa	ge 31 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155218	A. BUII B. WIN			07/28/2	011
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE N46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	limited to, use ho	oyer/sling lift for					
	transfers.						
	A reportable inci- was provided by was reviewed on indicated "Yester resident dressed, resident was com- right leg. Nurse resident's thigh w Nurse Practitions to be sent out for was admitted wit Resident has not when interviewed anything specific the fracture. Res X's (times) 2. In immediately beg Follow up: "All (Resident #E's na starting to compl interviewed. No occurrence or any contributed to the was called, he sta injury being self- she holds that leg information, faci substantiate that through mistreate An Alleged Abus	had any recent falls and d could not recall that happened to cause sident alert and oriented vestigation was un." staff that cared for ame) 48 hours prior to her ain of pain were ne reported any unusual ything that could have injury. When her son ated that he could see the inflicted due to the way g. Due to the above lity was unable to this injury occurred ment or accident.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218			ILDING	NSTRUCTION 00	ĺ	(3) DATE S COMPLE 07/28/20	ETED			
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY F LSC IDENTIFYING INFORMAI	ULL	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)		(X5) COMPLETION DATE		
TAG	provided with the CNA #4's descrip approximately 2: up in her wheeled take a nap. After 6:20 p.m. the CN resident's down, of the nurse's state CNA asked her to the resident to be CNA cleaned up resident did not be complain of pains. Review of the state indicated CNA # shift. The Hoyer Lift For the Administrator the procedure inclimited to, "Obtate another staff menuses as more considerable with R 10:20 a.m., indicated considerable with R 10:20 a.m., indicated considerable with the considerable with R 10:20 a.m., indicated considerable with the considerable with R 10:20 a.m., indicated considerable with the considerable with R 10:20 a.m., indicated considerable with the considerable with R 10:20 a.m., indicated considerable with R 10:20 a.m., indicated considerable with the considerable with R 10:20 a.m., indicated considerable with the consider	e investigation, indicate ption of incidence was a 30 p.m. the resident was hair. She did not want a dinner at approximate IA started to lay her Resident #E was in frost tion at 7:30 p.m. The constant toward her room and assiste the did not her room and assiste the the resident. The mave swelling and did not the provents of the resident.	ed at as to sly ont at as to sly ont at as to sly ont at a sly ont at	TAG				DATE		
	have done it hers staff always use sometime one sta	telf. She also indicated the lift to transfer her b aff member would sometimes two staff								
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Ever	nt ID: FXWC1	1 Facility l	D: 000123	If continuation she	et Pao	e 33 of 40		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLI	ETED
		155218	B. WIN			07/28/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REAT LAKES DRIVE		
REGENO	CY PLACE OF DYE	₹		1	IN46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	Interview with R	esident #E on 7/28/11 at					
	11:30 a.m., indic	ated she would tell staff					
	if something hap	pened. She had told					
	someone she wor	uld not tell because she					
	would not want t	o get anyone in trouble					
		bout it and now she					
		se if something happened					
	to her it could ha						
	15 Her it could ha	ppen to omeio.					
	Interview with th	ne Administrator on					
		p.m., indicated two staff					
		be present during a hoyer					
		further indicated she was					
	1	al information for					
		cated she had fallen. She					
		multiple staff had spoken					
	to her and she wo	ould not say she had					
	fallen or anything	g unusual had occurred.					
	Interview with th	e East Unit Manger on					
	7/28/11 at 1:55 p	.m., indicated when the					
	_	red Resident #E she did					
		ance of another staff					
		ast unit manager indicated					
		n instructed on the proper					
	use of the hoyer	IIIt.					
	Interview with th	ne Administrator on					
	_	.m., indicated she was					
		had transferred Resident					
	#E alone using th	ne hoyer lift.					
	1	relates to complaint					
	IN00093712.						

000123

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE OO COMPI					
AND PLAN	OF CORRECTION	155218	A. BUIL	DING	00	07/28/2	
		155216	B. WIN			0772072	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
REGENIC	Y PLACE OF DYER	2		DYER, I	REAT LAKES DRIVE		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
ing	REGULATORT OR	ESC IDENTIFY THOSE IN ORIVINION		ing	·		DATE
	3.1-45(a)(1)						
	3.1 -4 3(a)(1)						
F9999			l				
F 9999							
	STATE FINDING	GS	F9	999	F – 9999		08/19/2011
							00/19/2011
	3 1-13(g)(1)(D)	ADMINISTRATION			It is the practice of this facili	ty to	
	AND MANAGE				ensure the highest quality of	care	
	THIND WITH NICE	IVILIVI			is afforded our residents.		
	The administrato	r is responsible for the			Consistent with this practice,	the	
		ent of the facility but			following has been done:		
	_	as a departmental			771		
		_			The corrective action taken f		
	_	kample, director nursing			the residents found to have b		
		upervisor, during the			affected by the deficient practice was:	tice	
		responsibilities of the			Resident G no longer reside	oc in	
		all include, but are not			this facility.	.5 111	
	limited to, the fol				unis incincy.		
		informing the division					
		lowed by written notice			The corrective action taken f	or	
		ur hours, of unusual			those residents having the		
		directly threaten the			potential to be affected by the	e	
		or health of the resident or			same deficient practice is:		
		ing, but not limited to					
	any:				Nurse management conduc		
	(D) major accide	ents			a complete facility audit of		
					staff reported resident even		
		as not met as evidenced			occurring in the last 30 day ensure there were no further		
	by				unusual occurrences that	.1	
					needed to be reported. No		
		review and interview the			other issues were identified		
	facility failed to 1	-					
		DH (Indiana State			The measures put into place	and	
	Department of H	ealth) and thoroughly			systemic change made to ens		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155218	B. WIN			07/28/2011
NAME OF F	DROLUBER OR GURRY IER				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2300 G	REAT LAKES DRIVE	
	CY PLACE OF DYER	₹			IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·	DATE
		ecurrence for 1 of 1			the deficient practice does no	ν
		d for unusual occurrences			recur is:	
	in a sample of 8.	(Resident #G)			Do advection was provided	to
					Re-education was provided	
	Findings include	d:			the management staff by th district nurse consultant	e l
					related to reporting unusua	ı
	The record for R	esident #G was reviewed			occurrences related to resid	
	on 7/28/11 at 8:0	0 a.m. The resident's			events. Administration sha	
	diagnoses includ	ed, but were not limited			review 24 hour reports,	"
	to, diabetes melli	tus, renal disease,			Complaint/Grievance form	s
	hypothyroidism,				and any staff reported resid	I
	Jr. J ,				events daily (Monday throu	
	A nursing note d	ated 7/26/11 at 12:00			Friday) to ensure necessary	-
	T -	ne resident was alert and			reporting is completed in a	
	· ·	n and place. Her speech			timely manner.	
	1	• •				
		argor good, and mucus			To ensure the deficient practi	ice
		and pink. Her vital signs			does not recur, the monitorin	g
	were temperature				system established is:	
	_	plood pressure 128/50,			A Performance Improveme	l l
		ation 98%. Her AV			tool has been developed tha	ıt
	· ′	fistula (area used for			will monitor that unusual	
	* 1	ght arm had a palpable			occurrences are reported	
	bruit and thrill pr	resent. Her lungs were			appropriately as they occur	
	clear. Her abdon	nen was soft with bowel			DNS or Designee will comp	lete
	sounds present in	n four quadrants. Her			the PI tool weekly for four	
	pulses were palpa	able to her extremities			weeks, monthly for a quart	
		welling) was noted. The			and quarterly thereafter wi	th
		omplaints of pain. There			results forwarded to the PI	
		symptoms of hyper			committee ongoing for furt	ner
	_	ow) glycemia (blood			review.	
		n changes in insulin				
	• /	dent was repositioned				
	every two hours.	-				
	every two nours.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUI	LDING	00	COMPI 07/28/2	LETED	
		.03210	B. WIN		DDDEGG CITY OTHER ZID CORE	0.72072	
NAME OF I	PROVIDER OR SUPPLIE	R		1	DDRESS, CITY, STATE, ZIP CODE		
REGENO	CY PLACE OF DYE	R		DYER, I			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENC!)		DATE
	_	lated 7/26/11 at 6:15 a.m.,					
		al signs were blood					
	1 ^	pulse 71, respirations 14, 6 and oxygen saturation					
	_	sugar was 75. The					
		r sugar was 73. The					
		nedication after holding					
		th for several minutes.					
		ns up in the air. Her					
		pable in all extremities.					
		were dark blue in color.					
		. A bottle of pills were					
	_	side. The medication was					
		ng (milligrams). Thirteen					
		ne bottle. Staff unsure if					
	_	y of the medication. At					
	· ·	was no change in the					
		ion. Her speech was					
		rse practitioner was					
	_	a.m. nurse spoke to					
		he medication, Rifaximin					
	1 ^ -	c used to treat diarrhea.					
		idicated in excess it could					
	1 1	At 8:45 a.m. the					
		ion continued to decline.					
	1	is was declining. She was					
	sluggish and not	_					
	temperature was						
	1 ^	and blood pressure					
	_	ident's husband was					
		icated he would come to					
	I	8:50 a.m. the Nurse					
		paged to be informed.					
	The resident was	s becoming comatose.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	A. BUI	UILDING 00		COMPL	X3) DATE SURVEY COMPLETED 07/28/2011	
NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER			B. WING OTTZ6/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	bag of medication resident's drawer (pain medication unable to speak to obtained the med only reply was "Othe husband was resident did not resident was screwad a "crazed looresident's husbanhospital. The factoristic return call from the At 9:40 a.m. ther resident's condition Practitioner called case with staff. As send the resident called. At 9:50 a ambulance were no change in the late entry for 8:50 of medications for by the resident's wanted you to know I brought them as to why he had to the nurses, he	An order was received to to the hospital. 911 wasm. the police and at the facility. There was resident's condition. A 0 a.m., indicated the bag bund had been brought in husband. He stated, "I now what she was taking in in." When questioned not given the mediations indicate, "I don't know."						
	7/28/11 at 8:25 a resident had beer	e South Unit Manager on .m., indicated the admitted to the hospital of acute hepatic (liver)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 00 COM		(X3) DATE :	ETED	
155		155218	B. WIN			07/28/2	011
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
REGENCY PLACE OF DYER				1	REAT LAKES DRIVE IN46311		
					11140311		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	+	encephalopathy. She further indicated the					21112
	1 1 1	nd had told the staff the					
	resident had this happen in the past. He						
	thought it was due to her missing dialysis.						
	The Unit manager indicated the resident						
	had not missed dialysis. AT 8:55 a.m. the						
		ager indicated she has					
		spital and the resident					
	had an increase ammonia level and after a						
	couple of dialysis she was just fine.						
		J					
	Interview with the Administrator on						
	7/28//11 at 12:30 p.m., indicated the						
	occurrence had not been reported. She						
	had not felt it was an abuse situation. She						
	indicated the investigation completed was						
	the husband had	brought in the					
	medications and	with the initial diagnosis					
	she did not feel	she did not feel any other investigation					
	was warranted. She further indicated she did not know when the medications had been brought into the facility or how						
	many medication	ns were left.					
	_	conference on 7/28/11 at					
	_	outh Unit Manager,					
		l not know when the					
		been brought into the					
	1 -	counted the Tramadol					
		0 tablets in the container					
		dispensed but she did not					
	_ ·	were brought into the					
	facility. She did not count any of the						
	other medication	ns but Tramadol was the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			A. BUILDING B. WING		COMP	COMPLETED 07/28/2011	
NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE	
	only pain medica	ation found.					
	3.1-13(g)(1)(D)						